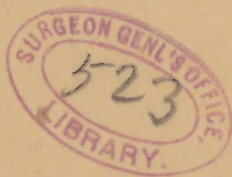


Laparotomy consecutive  
to a operation for suppurative  
appendicitis.

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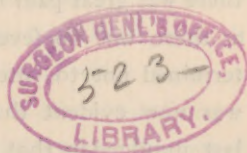


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## Laparotomy consecutive to an operation for Suppurative Appendicitis.

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Hector García, aet. 12. was taken ill on the 26<sup>th</sup> of May and Dr. F. Echeverría who was called in, diagnosed appendicitis. After treatment for several days, the case not doing well, Doctors J. Trumbull and N. Martínez were called in consultation. On the 4<sup>th</sup> of June I was invited to see the child, with a view to operating upon him. He had then fever (39.5), a quick pulse, general abdominal pain, more intense however in the iliac fossa. There was swelling in the right iliac fossa with marked dulness, and in the left, slight dulness on percussion. The patient vomited everything he took, and there was no action of the bowels. Urine of natural colour was freely passed. It was decided to operate on the following day. On the morning of the 5<sup>th</sup> the boy was placed on a table, chloroform administered, and the abdomen thoroughly washed with soap and warm water. An incision about 6 centimetres in length was made over the most prominent part of the dull region. A considerable quantity of pus escaped, and after irrigating the cavity with a warm solution of lysol (1—300), a coil of intestine was found lying immediately under the median side of the incision, which, had an exploratory puncture been made, would surely have been pierced. The finger introduced into the abscess cavity could not make out the appendix. This cavity, which

appeared to be circumscribed was well packed with thin strips of iodoform gauze and the wound itself covered with the same and absorbent cotton. For three days after the operation there was more or less vomiting, which was best allayed by the drinking of hot water. Until the 12<sup>th</sup> the temperature ranged about 37.5, after which it became normal. The pulse during the same time fell from 120 to 104, and after the 15<sup>th</sup> it did not rise above 80. Small quantities of champagne were given, and for three days after the operation, injections of peptonized food were administered. The packing of iodoform gauze was removed twenty-four hours after the operation, and the internal wound dressed with the gauze and cotton and lysol irrigations made twice a day. Four days after the operation, the bowels were for the first time moved. Everything now went on well for several days, with the exception of a certain sluggishness of the bowels, which required the use of enemata. I must however add, that for some days after the operation there was great pain in the left iliac fossa with a certain amount of dulness. But as there was no fever and no oedema of the skin could be detected, it was determined not to interfere, and most happily, as the pain soon passed off. As it was now evident that the bottom of the wound was closed, great hopes were at last indulged in, that all danger was at an end. On the 26<sup>th</sup> of June, however, the patient began to feel pain in his abdomen, which soon became intolerable. It was accompanied by vomiting of dark green colour, with complete and insuperable inaction of the bowels. The kidneys, however, continued to act freely. Withal, there was no rise in temperature, but the pulse went down to 54, becoming irregular and intermittent. The patient's features assumed a pinched look, and it was felt by all, that if relief were not quickly obtained, death would soon ensue. As there had been no rise in temperature and no rigors, it was not thought likely that these new features of the case could be due to retained pus, but that they were more probably owing to adhesions or peritoneal bands, obstructing the bowels. At 5 P. M. on the 2<sup>nd</sup> of July the case looked so desperate, that I decided upon operating as soon as all necessary arrangements could be made. At 8 P. M. the patient was chloroformed, and by the light of a gas chandelier and a couple of candles, I proceeded to open up the wound of the first operation. There was no escape of pus. On exploring I found the coil of intestine which I have already spoken of, adherent to the parietal peritoneum. This was gently and at the same time easily detached. Further, two thin bands to the left of the median line were found, binding down intestinal coils but not being within easy reach the incision was

freshened up, and brought together with five silk sutures, and a median laparotomy proceeded with at once. This was 10 centimetres in length, the umbilicus being exactly at its middle point. A dense band was found 6 centimetres in width, firmly holding down, but not adherent to the intestines beneath. This divided with scissors, the intestines, considerably inflated, were so to say, shot out, but at once covered with cloths wrung out in warm water. The other two small bands were now tied with catgut and cut, and the intestines after some difficulty replaced and kept in place by the introduction of a large flat new sponge, which had been cleansed in the house and allowed to soak for a couple of hours in a lysol solution (1—100). The incision was closed with nine silk sutures and covered with gauze and cotton. On the following morning the temperature was 37.8 and pulse 120. This time there was very little vomiting, but the pain was so great, that for two nights following it was found necessary to inject Morphia subcutaneously. On the 4<sup>th</sup> day, the bowels were naturally and freely moved. The pulse went down to 75—80 and the temperature became normal. On the 7th day the sutures were all removed leaving slight suppuration in the tracks of two of them, which however soon disappeared. With the exception of two attacks of colic which required castor oil, convalescence was uninterrupted, and at this date the patient is in the best of health.

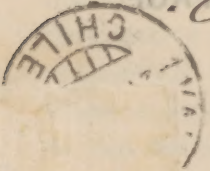
**Dr. OLOF PAGE.**

*Valparaiso, September 8<sup>th</sup>, 1894.*

dissected up and brought together with fine silk sutures and a medical preparation  
prescribed with at once. This was in circumstances in which the incision was being  
extended at its middle point. A short time was passed & the incision was with  
firmly holding down, but not adherent to the internal part. This showed  
with science, the incision, considerably inflamed, was so to say, shut out, but as  
was covered with cloth wetted out in warm water. The other two small bands  
were now tied with catgut and cut, and the incision after some difficulty repaired  
and kept in place by the introduction of a large flat new sponge, which had been  
steamed in the house and allowed to soak for a couple of hours in a good solution  
(1-1000). The incision was closed with nine silk sutures and covered with gauze  
and cotton. On the following morning the temperature was 97.5 and pulse 120.  
The next day was very little working, but the patient was kept in bed. On the  
night following it was found necessary to inject Morphine subcutaneously. On the  
10th day the bowels were naturally and freely moved. The pain went down to  
75-80 and the temperature became normal. On the 11th day the patient was all  
around having slight suppuration in the track of two of the incisions, which however  
soon disappeared. With the exception of this the patient is in the best of  
health.

*W. D. Johnson*

*D. J. Johnson*



September 20, 1894.

*W. D. Johnson*



